MDR Tracking Number: M5-04-2611-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 04-16-04.

The IRO reviewed special reports, office visits, myofascial release, joint mobilization, ultrasound, electrical stimulation (unattended), therapeutic exercises, manual therapy technique and therapeutic procedures rendered from 05-28-03 through 08-15-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
05-28-03 05-30-03 06-02-03 06-04-03 06-06-03 06-09-03 06-11-03 06-13-03 (8 DOS)	97250	$344.00 (1 unit @ $43.00 X 8 DOS)	$0.00	V	$43.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the amount of $43.00 X 8 DOS = $344.00
06-16-03 06-18-03 06-20-03 06-25-03 06-30-03 07-02-03 07-09-03 (7 DOS)	97250	$301.00 (1 unit @ $43.00 X 7 DOS)	$0.00	V	$43.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
05-28-03 05-30-03 06-02-03 06-04-03 06-06-03 06-09-03 06-11-03 06-13-03 (8 DOS)	97265	$344.00 (1 unit @ $43.00 X 8 DOS)	$0.00	V	$43.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the amount of $43.00 X 8 DOS = $344.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
06-16-03 06-18-03 06-20-03 06-25-03 06-30-03 07-02-03 07-09-03 (7 DOS)	97265	$301.00 (1 unit @ $43.00 X 7 DOS)	$0.00	V	$43.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
05-28-03 05-30-03 06-02-03 06-04-03 06-06-03 06-09-03	97035	$280.00 (1 unit @ $35.00 X 8 DOS)	$0.00	V	$22.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the amount of $22.00 X 8 DOS = $176.00

06-11-03 06-13-03 (8 DOS)							
05-28-03 05-30-03 06-02-03 06-04-03 06-06-03 06-09-03 06-11-03 (8 DOS)	97014	$120.00 (1 unit @ $15.00 X 8 DOS)	$0.00	V	$15.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the amount of $15.00 X 8 DOS = $120.00
08-01-03 08-06-03 08-08-03 08-11-03 08-13-03 08-15-03 (6 DOS)	97140	$420.00 (2 units @ $70.00 X 6 DOS)	$0.00	V	$33.90 ($27.12 participating amount X 125% per Medicare Fee Schedule)	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
06-16-03 06-18-03 06-20-03 06-25-03 06-30-03 07-02-03 07-09-03 (7 DOS)	97150	$490.00 (2 units @ $70.00 X 7 DOS 14 units total billed)	$0.00	V	$27.00	IRO DECISION	IRO determined 1 unit of service for DOS 06-16-03 through 07-09-03 was medically necessary. Reimbursement recommended in the amount of $27.00 X 7 DOS = 189.00
08-01-03 08-06-03 08-08-03 08-11-03 08-13-03 08-15-03 (6 DOS)	97150	$300.00 (2 units @ $50.00 X 6 DOS 12 units total billed)	$0.00	V	$23.61 ($18.89 participating amount X 125% per Medicare Fee Schedule)	IRO DECISION	IRO determined 1 unit of service for DOS 08-01-03 through 08-15-03 was medically necessary. Reimbursement recommended in the amount of $141.66

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
06-16-03 06-18-03 06-20-03 06-25-03 06-30-03 07-02-03 07-09-03 (7 DOS)	97110	$1,470. 00 (6 units @ $210.0 0 X 7 DOS 42 units total billed)	$0.00	V	$35.00	IRO DECISION	IRO determined 2 units of service were medically necessary. Reimbursement recommended in the amount of $70.00 (2 units) X 7 DOS =$490.00
08-01-03 08-06-03 08-08-03 08-11-03 08-13-03 08-15-03 (6 DOS)	97110	$1,440. 00 (6 units @ $240.0 0 X 6 DOS 36 units	$0.00	V	$35.91 ($28.73 participating amount X 125% per Medicare Fee Schedule)	IRO DECISION	IRO determined 2 units of service were medically necessary. Reimbursement recommended in the amount of $71.82 (2 units) X 6 DOS = $430.92

		total billed)					
05-28-03 06-02-03 06-09-03 06-16-03 06-25-03 06-30-03 (6 DOS)	99213	$288.00 (1 unit @ $48.00 X 6 DOS)	$0.00	V	$48.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
08-06-03 08-11-03 (2 DOS)	99213	$140.00 (1 unit @ $70.00 X 2 DOS)	$0.00	V	$65.21 ($52.17 participating amount X 125% per Medicare Fee Schdule)	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
05-30-03 06-04-03 06-06-03 06-11-03 06-13-03 06-18-03 06-20-03 07-02-03 07-09-03 (9 DOS)	99212	$288.00 (1 unit @ $32.00 for 9 DOS)	$0.00	V	$32.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
08-01-03 08-08-03 (2 DOS)	99212	$100.00 (1 unit @ $50.00 X 2 DOS)	$0.00	V	$46.14 ($37.13 participating amount X 125% per Medicare Fee Schedule)	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
05-28-03 05-30-03 06-02-03 06-06-03 06-09-03 06-11-03 06-13-03 (7 DOS)	99080	$3.50 (1 unit @ .50 X 7 DOS)	$0.00	V	DOP	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
06-04-03 06-16-03 06-18-03 06-20-	99080	$14.00 (1 unit @ $1.00 X 14 DOS)	$0.00	V	DOP	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.

03 06-25-03 06-30-03 07-02-03 07-09-03 08-01-03 08-06-03 08-08-03 08-11-03 08-13-03 08-15-03 (14 DOS)							
TOTAL		$6,693.50					The requestor is entitled to reimbursement of **$2,235.58**

The IRO concluded that office visits and special reports from 05-28-03 through 08-15-03, joint mobilization, myofascial release, electrical stimulation (unattended), ultrasound and manual therapy techniques from 06-16-03 through 08-15-03 and greater than one unit of therapeutic procedures and greater than two units of therapeutic exercises from 06-16-03 through 08-15-03 **were not** medically necessary. The IRO concluded that myofascial release, joint mobilization, ultrasound, electrical stimulation (unattended) and manual therapy techniques from 05-28-03 through 06-13-03 and one unit of therapeutic procedure and two units of therapeutic exercises from 06-16-03 through 08-15-03 **were** medically necessary.

On this basis, the total amount recommended for reimbursement **($2,235.58)** does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This Findings and Decision is hereby issued this 16th day of July 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 05-28-03 through 08-15-03 in this dispute.

This Order is hereby issued this 16th day of July 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

July 2, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: ___
MDR Tracking #: M5-04-2611-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 63-year-old male had a work related accident ___. He stepped out of his truck onto a rock twisting his ankle and losing his balance; he slipped and fell against his truck sustaining injuries to the mid low back and right knee. An MRI of the right knee revealed degenerative joint disease and a tear of the medial meniscus, but no evidence of acute or traumatic pathology. His treatment has included physical therapy, use of a cane, range of motion testing, pain management, and electrical stimulation.

Requested Service(s)

Special reports, office visits, myofascial release, joint mobilization, ultrasound, electrical stimulation (unattended), therapeutic exercises, manual therapy technique, and therapeutic procedures were denied.

Decision

It is determined that the myofascial release, joint mobilization, ultrasound, electrical stimulation (unattended), and manual therapy techniques from 05/28/03 through 06/13/03 were medically necessary for this patient's condition. In addition, one unit of therapeutic procedure (97150) and two units of therapeutic procedures (97110) from 06/16/03 through 08/15/03 were medically necessary for this patient's condition.

It is determined that the office visits and special reports from 05/28/03 through 08/15/03 are not medically necessary to treat this patient's condition. Joint mobilization, myofascial release, electrical stimulation (unattended) ultrasound, and manual therapy techniques from 06/16/03 through 08/15/03 are not medically necessary for this patient's condition. In addition, greater than one unit of therapeutic procedures (97150) and greater than two units of therapeutic procedures (97110) from 06/16/03 through 08/15/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The treating doctor's documentation forwarded for review does not support all the services that were billed from 05/28/03 through 08/15/03. The durations and service units changed are highly atypical among rehabilitation professionals. The reduced units seem more applicable to the transition from passive to active care. The provider initiated therapeutic exercise on 06/16/03 which was a signal that active therapeutics would be utilized in the management of the claimant's condition.

Since an active therapeutic paradigm was adopted the medical necessity and appropriateness of continued passive management is highly questionable and not applicable to the treatment of this claimant's condition.

Treating provider does establish that the claimant is an older gentleman and that a rapid resolution of a pain complaint in the strain/sprain therapeutic algorithm may not be possible given the claimant's age. Diagnostic imaging over the right knee does not lead convincingly to an acute pain source/pain generator that is resultant of the injury event on ___. There is a great degree of degenerative changes that are suspected to have been present for a considerable period of time. The MR imaging of the lumbar spine does reveal current pain generators that can be contributing to the S1 right radiculopathy that the claimant is currently experiencing.

Functional progress is noted in qualitative/quantitative manner that warrants the application of rehabilitation therapeutics in a passive capacity from 05/28/03 through 06/13/03 and rehabilitation applications in an active capacity from 06/16/03 through 08/15/03.

Surgical applications over the right knee do not appear warranted and/or related with medical certainty to the injury event on ___. Dysfunction experienced by the claimant may warrant transition to an upper level therapeutic program.

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer-reviewed references.

- Carette S, et al. *Epidural corticosteroid injections for sciatica due to herniated nucleus pulposus.* N Engl J Med. 1997 Jun 5; 336 (23):1634-40.
- Kankaanpaa M, et al. *The efficacy of active rehabilitation in chronic low back pain. Effect on pain intensity, self-experience disability, and lumbar fatigability.* Spine. 1999 May 15; 24(10):1034-42.
- *Overview of implementation of outcome assessment case management in the clinical practice.* Washington State Chiropractic Association; 2001. 54p.
- Thomas KS, et al. *Home based exercise programme for knee pain and knee osteoarthritis: randomized controlled trial.* BMJ. 2002 Oct 5; 325(7367):752.

Sincerely,